



**Department of Veterans Affairs
Office of Inspector General**

Office of Healthcare Inspections

Report No. 08-02418-202

Combined Assessment Program Review of the Sheridan VA Medical Center Sheridan, Wyoming



August 25, 2009

Washington, DC 20420

Why We Did This Review

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high quality health care is provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections and Investigations to provide collaborative assessments of VA medical facilities on a cyclical basis. The purposes of CAP reviews are to:

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical services.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

In addition to this typical coverage, CAP reviews may examine issues or allegations referred by VA employees, patients, Members of Congress, or others.

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Executive Summary

Introduction

During the week of June 8–11, 2009, the OIG conducted a Combined Assessment Program (CAP) review of the Sheridan VA Medical Center (the medical center), Sheridan, WY. The purpose of the review was to evaluate selected operations, focusing on patient care administration and quality management (QM). During the review, we also provided fraud and integrity awareness training to 151 medical center employees. The medical center is part of Veterans Integrated Service Network (VISN) 19.

Results of the Review

The CAP review covered seven operational activities. We identified the following organizational strengths and reported accomplishments:

- Horses for Heroes Program.
- Soft Suicide Prevention Doors.
- Point of Care Reviews.

We made recommendations in four of the activities reviewed; one recommendation was a repeat recommendation from the prior CAP review. For these activities, the medical center needed to:

- Ensure that privileges granted to contract providers do not extend beyond the contract period.
- Monitor the use of the copy and paste functions in the electronic medical record (EMR).
- Conduct environmental rounds in all patient care areas and document results.
- Complete discharge documentation, as required by local policy.
- Consistently document the effectiveness of all pain medications within the required timeframe of the local policy.

The medical center complied with selected standards in the following three activities:

- Emergency/Urgent Care (E/UC) Operations.
- Suicide Prevention.
- Survey of Healthcare Experiences of Patients (SHEP).

This report was prepared under the direction of Dorothy Duncan, Associate Director, and Jennifer Kubiak, Healthcare Inspector, Kansas City Office of Healthcare Inspections.

Comments

The VISN and Medical Center Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 13–16, for full text of the Directors' comments). We will follow up on the planned actions until they are completed.

*(original signed by Dana Moore, PhD
Deputy Assistant Inspector General for
Healthcare Inspections for:)*

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Introduction

Profile

Organization. The medical center is the tertiary mental health (MH) facility for VISN 19 and is located in Sheridan, WY. It provides inpatient acute, transitional, and residential care as well as domiciliary residential rehabilitation, community treatment, and outpatient care. Outpatient care is also provided at five community based outpatient clinics (CBOCs) in Casper, Gillette, Riverton, Rock Springs, and Powell, WY. The medical center is part of VISN 19 and serves a veteran population of about 34,000 throughout 15 counties in northern and western Wyoming.

Programs. The medical center provides medical, MH, geriatric, domiciliary, and rehabilitation services. It has 73 hospital beds and 50 community living center (CLC) beds.¹

Affiliations and Research. The medical center is affiliated with the University of Washington School of Medicine and with other colleges and universities to train nursing, dental assistant/hygienist, physical therapy, physician assistant, and social work students. The medical center has no medical residents and does not conduct research.

Resources. In fiscal year (FY) 2008, medical care expenditures totaled \$53 million. The FY 2009 medical care budget is \$56 million. FY 2008 staffing was 457 full-time employee equivalents (FTE), including 20 physician and 80 nursing FTE.

Workload. In FY 2008, the medical center treated 11,778 unique patients and provided 20,141 inpatient days in the hospital and 15,928 inpatient days in the CLC. The inpatient care workload totaled 1,336 discharges, and the average daily census, including CLC patients, was 100. Outpatient workload totaled 109,956 visits.

Objectives and Scope

Objectives. CAP reviews are one element of the OIG's efforts to ensure that our Nation's veterans receive high quality VA health care services. The objectives of the CAP review are to:

¹ A CLC (formerly called a nursing home care unit) provides compassionate, person-centered care in a safe and homelike environment to eligible veterans who require a nursing home level of care.

- Conduct recurring evaluations of selected health care facility operations, focusing on patient care administration and QM.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Scope. We reviewed selected clinical and administrative activities to evaluate the effectiveness of patient care administration and QM. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of care to identify and correct harmful and potentially harmful practices and conditions.

In performing the review, we inspected work areas; interviewed managers and employees; and reviewed clinical and administrative records. The review covered the following seven activities:

- Coordination of Care.
- E/UC Operations.
- Environment of Care (EOC).
- Medication Management.
- QM.
- SHEP.
- Suicide Prevention.

The review covered medical center operations for FY 2008 and FY 2009 through June 11, 2009, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on select recommendations from our prior CAP review of the medical center (*Combined Assessment Program Review of the Sheridan VA Medical Center, Sheridan, Wyoming*, Report No. 06-00636-44, December 15, 2006). The medical center had corrected all but one finding related to health care from our prior CAP review. That finding is discussed in the EOC section of this report.

In addition, we followed up on recommendations from a prior OIG inspection (*Assessment of Legionnaire's Disease Risk in Veterans Health Administration Inpatient Facilities*, Report

No. 07-00029-151, June 20, 2007). The inspection surveyed inpatient facilities, including the medical center, for Legionnaire's disease (LD) prevention strategies. We found that the medical center has a written plan that addresses the prevention of LD and that the medical center is consistently performing monthly LD risk assessments. We consider the medical center to be in compliance with the recommendations.

During this review, we also presented fraud and integrity awareness briefings for 151 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. Activities in the "Review Activities Without Recommendations" section have no reportable findings.

Organizational Strengths

Horses for Heroes Program

This program assists veterans with varying degrees of injuries to learn new skills while participating in unique physical therapy. Horses are therapeutic for amputees by aiding in the recovery of movement essential for walking. Horses are also therapeutic for relaxation and aid patients with MH conditions to develop decision making skills. Beginning in 2008, a local organization offered the medical center a unique opportunity for veterans to work with horses in one of four individual 8-week sessions. Each veteran is assessed, and a program is developed around his or her needs and abilities. The sessions begin with grooming and saddling and end with riding the horses. Not all veterans are able to ride the horses, but no veteran has ever been disappointed with the time spent in this program.

Soft Suicide Prevention Doors

In an effort to improve safety in the MH environment and at the same time provide patient privacy, the medical center developed a lightweight, attractive, and safe door for use on the bathroom of any patient for whom there is concern for suicide. The door, which is made of soft foam and vinyl, covers the middle section of the doorway. This allows care providers to observe the patient's feet and head while he or she is in the bathroom but maintains patient privacy. The door cannot be used as a weapon and is fire resistant.

Outdoor scenes printed on the doors also provide artwork for the rooms. The medical center has received a patent for this product, and the door is gaining recognition throughout the United States.

Point of Care Reviews

Medical record reviews are required at the point of care to capture opportunities to improve medical record documentation. In order to streamline the data captured during these reviews and create reports for medical center program managers, QM staff developed an electronic database that can be used for direct data entry at the point of review. The electronic database eliminates the need for paper review sheets and separate data entries and provides instant access to data and reports.

Results

Review Activities with Recommendations

Quality Management

The purpose of this review was to evaluate whether the medical center's QM program provided comprehensive oversight of the quality of care and whether senior managers actively supported the program's activities. We interviewed the medical center's senior management team and QM personnel. We evaluated plans, policies, and other relevant documents.

Service chiefs collected and utilized appropriate quality data to evaluate physician performance for granting and renewing clinical privileges, as required by VHA. We reviewed 18 physician profiles and found that all had relevant practitioner-specific data to support renewal of clinical privileges. Additionally, all physicians had appropriate privileges for their specialties and for procedures performed.

The QM program was generally effective in providing oversight of the medical center's quality of care, and senior managers supported the program. Appropriate review structures were in place for 12 of the 14 program activities reviewed. We identified two areas that needed improvement.

Privileging of Contract and Fee Basis Providers. The medical center did not grant privileges to contract and fee basis providers according to the length of the association with the medical center. Clinical privileges granted to contractors may not extend beyond the contract period.

Each new contract requires reappraisal and reprivileging.² We reviewed 5 (17 percent) of the 29 contract or fee basis providers' credentialing and privileging files and found that all 5 had privileges granted for a 2-year period even though the contracts were limited to time periods ranging from a few months to 1 year. These providers would have privileges at the medical center after their contracts expired.

Medical Record Review. Although the medical center maintained a process to monitor open and closed medical records on an ongoing basis, this process did not include monitoring the copy and paste functions in the EMR. VHA requires that each facility have rules guiding the use of the copy and paste functions in the EMR.³ Someone other than the author of the original progress note could copy and paste information regarding examinations performed or treatment provided, creating ethical and legal problems. Although the medical center had rules that outlined accountability for monitoring the copy and paste functions, no monitoring had occurred.

Recommendation 1

We recommended that the VISN Director ensure that the Medical Center Director requires that clinical privileges granted to contract providers do not extend beyond the contract period.

The VISN and Medical Center Directors agreed with the finding and recommendation. Medical center staff have developed a process for communicating contract providers' appointment limitations, and the privileges granted are now limited to the duration of the anticipated appointments. The corrective actions are acceptable, and we consider this recommendation closed.

Recommendation 2

We recommended that the VISN Director ensure that the Medical Center Director requires that the medical record review process includes monitoring the use of the copy and paste functions in the EMR.

The VISN and Medical Center Directors agreed with the findings and recommendation. The record review form used for the Ongoing Professional Practice Evaluation will be updated to include the use of the copy and paste functions in the medical record. The implementation plans are

² VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.

³ VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.

acceptable, and we will follow up on the planned actions until they are completed.

Environment of Care

The purpose of this review was to determine whether the medical center complied with selected infection control standards and maintained a clean and safe health care environment. VHA facilities are required to provide a comprehensive EOC program that fully meets VA National Center for Patient Safety, Occupational Safety and Health Administration, and Joint Commission (JC) standards.

We conducted onsite inspections of the inpatient medical, acute psychiatry, and special needs units; the CLC; and outpatient care areas. The medical center maintained a clean and safe environment. Staff and nurse managers expressed satisfaction with the responsiveness of the housekeeping staff on their units. Medical center managers conducted the required quarterly MH EOC assessments for the locked psychiatry unit. However, a finding from the prior CAP review continued to need improvement.

Environmental Rounds. Medical center managers did not have evidence that the EOC Committee conducted semi-annual rounds at the CBOCs. Members of the committee stated that they conducted the rounds as required. However, they could not provide supporting documentation, and results were not reflected in committee minutes. The Deputy Under Secretary for Health for Operations and Management (DUSHOM) requires that the EOC Committee inspect facility sites, including all remote care sites, at least semi-annually.⁴

Recommendation 3

We recommended that the VISN Director ensure that the Medical Center Director requires that the EOC Committee conduct environmental rounds in all patient care areas and document results, as required by the DUSHOM.

The VISN and Medical Center Directors agreed with the findings and recommendation. The Chair of the EOC Committee will ensure that all EOC rounds, including those conducted at the CBOCs, are documented in the electronic database and that EOC Committee minutes include documentation that the results were reviewed. The

⁴ DUSHOM, "Environmental Rounds," memorandum, March 5, 2007.

implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Coordination of Care

The purpose of this review was to evaluate whether inpatient consultations, intra-facility (ward-to-ward) transfers, and discharges were appropriately coordinated over the continuum of care and met VHA and JC requirements. Coordinated consultations, transfers, and discharges are essential to an integrated, ongoing care process resulting in optimal patient outcomes.

We reviewed the medical records of 12 inpatients who had consults ordered and performed internally. In general, we found that inpatients received consultative services within acceptable timeframes. We also reviewed the medical records of 12 inpatients who were transferred within the medical center. In general, we found that inpatient transfers had the required medical record documentation specified in local policy. However, we identified the following area that needed improvement.

Discharge Documentation. We determined that 3 (25 percent) of 12 discharges did not have the required medical record documentation specified by local policy. Local policy requires staff to provide patient discharge instructions that contain discharge medications and recommended diet, activity level, and follow-up. In addition, documentation must include that the patient and/or significant other understood these instructions.

Recommendation 4

We recommended that the VISN Director ensure that the Medical Center Director requires staff to complete discharge documentation, as required by local policy.

The VISN and Medical Center Directors agreed with the findings and recommendation. Discharge instruction documentation will include mandated fields to ensure that required elements are incorporated. Also, documentation of acknowledgement of receipt and understanding of the instructions will be required. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Medication Management

The purpose of this review was to evaluate whether VHA facilities had adequate medication management practices. A safe medication management system includes medication ordering, administering, and monitoring.

We reviewed selected medication management processes in the inpatient medical, acute psychiatry, and special needs units and in the CLC. We found adequate management of medications brought into the facility by patients or their families. Nurses appropriately scanned patient armbands and used personal identifiers prior to medication administration. We identified the following area that needed improvement.

Documentation of Pain Medication Effectiveness. Nurses did not consistently document the effectiveness of pain medications in accordance with local policy requirements. We reviewed the Bar Code Medication Administration records of 19 patients who were hospitalized in selected units at the time of our visit. For each patient, we reviewed documentation for several doses of pain medication. Nurses documented pain medication effectiveness within the locally required 4-hour timeframe for 87 (81 percent) of the 108 doses of pain medication.

Medical center managers had recently implemented action plans to improve documentation of pain medication effectiveness. Although compliance with documentation requirements had increased, it continued to need improvement.

Recommendation 5

We recommended that the VISN Director ensure that the Medical Center Director requires that nurses consistently document the effectiveness of all pain medications within the required timeframe of the local policy.

The VISN and Medical Center Directors agreed with the finding and recommendation. Nursing Service has created reminder signage to emphasize documentation of medication effectiveness. Weekly reports will be generated to monitor compliance. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Review Activities Without Recommendations

Emergency/Urgent Care Operations

The purpose of this review was to evaluate whether VHA facility E/UC operations complied with VHA guidelines related to hours of operation, clinical capability (including management of patients transferred to other facilities), staffing adequacy, and staff competency. In addition, we inspected the medical center's urgent care clinic (UCC) for cleanliness and safety. The UCC is located within the main hospital building and is open 24 hours per day, 7 days per week.

We reviewed medical records of patients who presented to the UCC and found that staff managed the patients' care appropriately. We reviewed the UCC nurse staffing plans and time schedules and determined that managers had consistently followed their established staffing guidelines for allocating nursing resources. We also found that managers had appropriately documented nurse competencies.

We determined that the UCC complied with VHA operational standards for inter-facility transfers, admissions, staffing guidelines, cleanliness, and competency. We made no recommendations.

Suicide Prevention

The purpose of this review was to determine whether the medical center had implemented a suicide prevention program that was in compliance with VHA regulations. We assessed whether senior managers had appointed a Suicide Prevention Coordinator (SPC) at the medical center and at any very large CBOCs, and we evaluated whether the SPC fulfilled all required functions.⁵ We also verified whether medical records of patients determined to be at high risk for suicide contained Category II Patient Record Flags (PRFs), documented safety plans that addressed suicidality, and documented collaboration between MH providers and the SPC.⁶

We interviewed the medical center SPC, and we reviewed pertinent policies and the medical records of seven medical center patients and three CBOC patients determined to be at high risk for suicide. All 10 medical records had Category II PRFs. We found that senior managers had appropriately appointed the SPC and that the SPC fulfilled the required

⁵ Very large CBOCs are defined as clinics with more than 10,000 unique patients enrolled.

⁶ A Category II PRF is an alert mechanism that is displayed prominently in medical records.

functions.⁷ Nine (90 percent) of the 10 medical records reviewed had documented safety plans that addressed suicidality. Although documented collaboration between MH providers and the SPC could be improved, a Suicide Case Manager had been hired within the last 2 months to assist with workload. Because the program was generally effective, we made no recommendations.

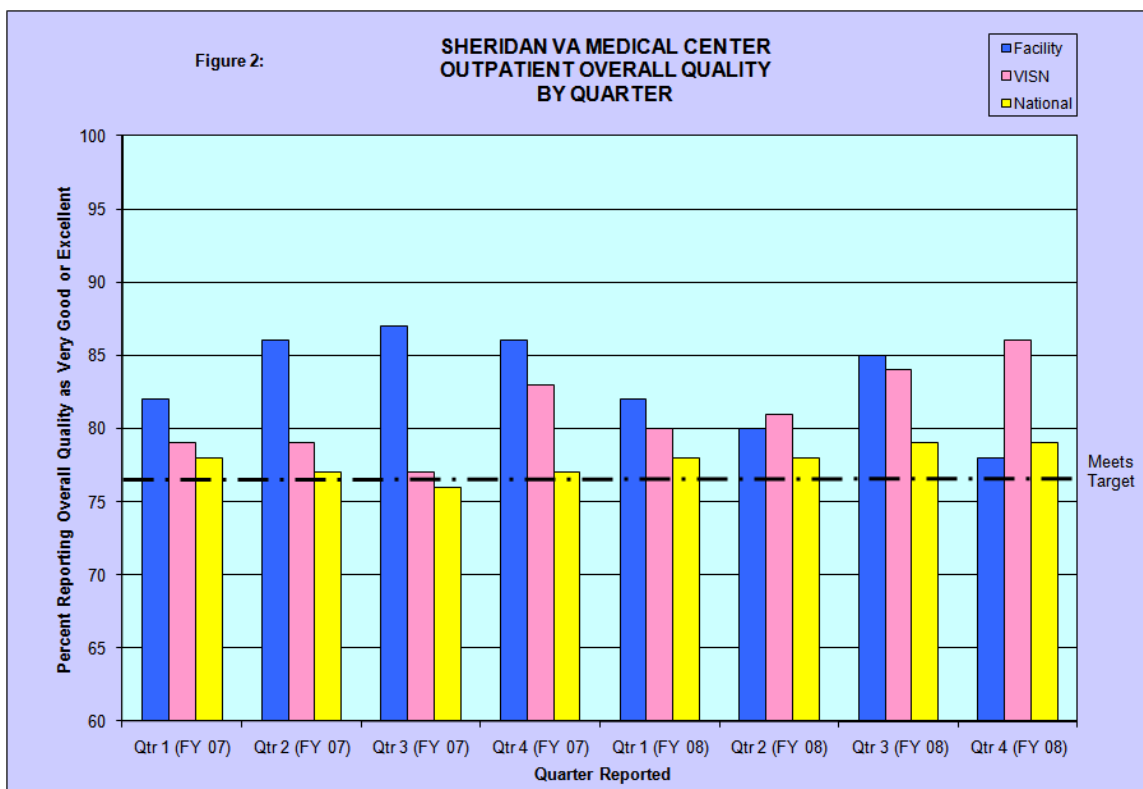
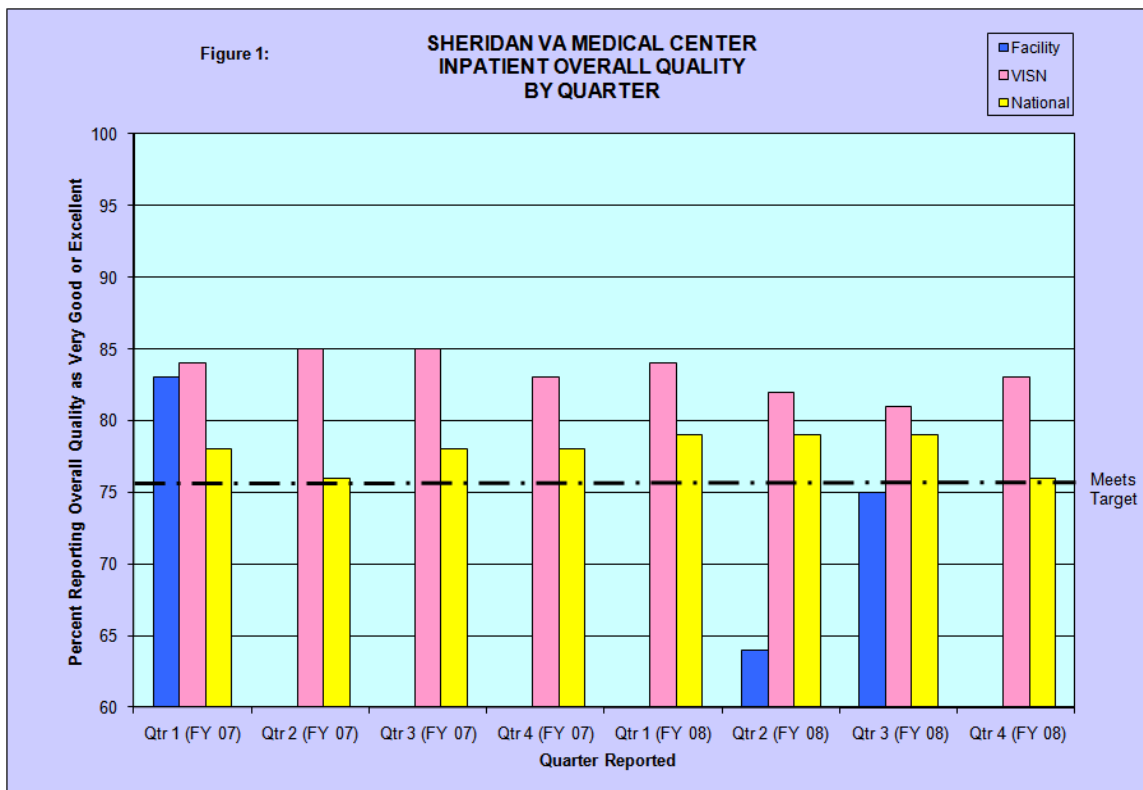
Survey of Healthcare Experiences of Patients

The purpose of this review was to assess the extent that VHA medical centers used quarterly survey results of patients' health care experiences with the VHA system to improve patient care, treatment, and services. The Performance Analysis Center for Excellence of the Office of Quality and Performance (OQP) within VHA is the analytical, methodological, and reporting staff for SHEP. VHA set performance measure goals for patients reporting overall satisfaction of "very good" or "excellent" at 76 percent for inpatients and 77 percent for outpatients. Medical centers are expected to address areas that fall below target scores.

We reviewed inpatient and outpatient survey results for FYs 2007 and 2008. Figures 1 and 2 on the next page show the medical center's SHEP performance measure results for inpatients and outpatients, respectively.⁸

⁷ VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008.

⁸ Data for inpatient overall quality was not available on the OQP website for 5 of the 8 quarters.



The medical center exceeded the target for all 8 quarters for outpatient quality; however, inpatient quality dropped to a low of 64 percent in FY 2008. This was attributed to changes in patient care delivery for MH services. Patients were dissatisfied with their involvement in decisions about their care. Medical staff leadership implemented a requirement that MH providers see each patient on an individual basis to address these concerns. As a result, scores are improving. The Patient Advocate provided a comprehensive plan that facilitates successful results for high patient satisfaction scores. In collaboration with Patient Advocate Liaisons, the committee that addresses patient satisfaction proactively addresses potential issues and communicates report results to medical center staff.

Effective October 1, 2008, VHA changed to a new survey process. We reviewed 1st quarter data and noted that the medical center exceeded the targets. We made no recommendations.

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: August 3, 2009

From: Director, VA Rocky Mountain Network (10N19)

Subject: **Combined Assessment Program Review of the Sheridan
VA Medical Center, Sheridan, Wyoming**

To: Director, Chicago and Kansas City Offices of Healthcare
Inspections (54CH/KC)

Director, Management Review Service (10B5)

I have reviewed the OIG Combined Assessment Program Review of the Sheridan VAMC and concur with the responses as provided by the Medical Center Director. If you have any questions, please contact Ms. Anita Urdiales, HSS, at 303.756.9279.

(original signed by:)

GLEN W. GRIPPEN, FACHE

Medical Center Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: July 29, 2009

From: Director, Sheridan VA Medical Center (666/00)

Subject: **Combined Assessment Program Review of the Sheridan
VA Medical Center, Sheridan, Wyoming.**

To: Director, VA Rocky Mountain Network (10N19)

1. After reviewing the report, I concur with the findings identified.
2. The Sheridan VA Medical Center has developed and implemented the following action plans with designated anticipated completion dates.
3. Please contact Lisa McClintock at 307.675.3165 or myself at 307.675.3675 with any questions or concerns regarding the following action plans.

(original signed by:)
DEBRA L. HISCHMEN

Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General report:

OIG Recommendations

Recommendation 1. We recommended that the VISN Director ensure that the Medical Center Director requires that clinical privileges granted to contract providers do not extend beyond the contract period.

Concur

Target Completion Date: Completed

The Credentialing, Contracting, and Acquisition staff have developed a process for communicating appointment limitations on contract and locum tenens providers to limit the privileges granted to contract and locum providers to the duration of their anticipated appointment. All contract providers that have been hired since the OIG review have been compliant with this requirement.

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director requires that the medical record review includes monitoring the use of the copy and paste functions in the EMR.

Concur

Target Completion Date: September 30, 2009

Updates to the peer record review form used for the OPPE will include the use of the copy and paste function in the medical record.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requires that the EOC Committee conduct environmental rounds in all patient care areas and document results, as required by the DUSHOM.

Concur

Target Completion Date: Completed

The Chair of the EOC Committee has ensured the documentation of each environment of care review in each area of the medical center and CBOCs is documented in the electronic VISN 19 database with additional review in the EOC Committee minutes.

Recommendation 4. We recommended that the VISN Director ensure that the Medical Center Director requires staff to complete discharge documentation, as required by local policy.

Concur

Target Completion Date: September 30, 2009

Mandated fields in the discharge instruction documentation for providers and nursing staff will ensure that diet, activity, a medication list for home, and follow-up information are consistently provided to all discharged patients as well as the documentation of acknowledgement of receipt and understanding of the instructions.

Recommendation 5. We recommended that the VISN Director ensure that the Medical Center Director requires that nurses consistently document the effectiveness of all pain medications within the required timeframe of the local policy.

Concur

Target Completion Date: August 31, 2009

Nursing Service has created reminder signage to aid with completing PRN effectiveness documentation timely. A competition was developed for individual and unit performance improvement using weekly data pulls provided by the Clinical Applications Coordinator and the Quality Manager. Weekly reports by the nurse managers for compliance and noncompliance will be forwarded to the Deputy Nurse Executive. A weekly summary will be provided to the Associate Director for Nursing and Patient Care Services. At the time of this response, the facility average for PRN effectiveness timely documentation has reached 91%.

OIG Contact and Staff Acknowledgments

| | |
|---------------------|--|
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